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Continuing Professional Development (CPD) – putting the learner back at the centre

Abstract

Continuing professional development (CPD) is changing. Once seen as flexible on the basis of personal choice and mainly consisting of conferences and lecture style meetings, it is now much more likely to be specified, mandatory and linked to specific regulatory or quality improvement activities. This may not be well aligned with how adult professionals learn best and the evidence of resulting change in practice is limited. Also there is a danger of losing out on serendipity in learning by pushing experienced professionals into focusing excessively on mandatory activities that seem to be increasingly ‘ticking the box’. However, the previous impression of flexibility may have hidden poor education practice.

This paper defines CPD and asks whether there are problems with CPD. It looks at how adults are thought to learn and places this in the context of current practice. It considers practical models of how to deal with a series of common challenges met by those who provide and undertake CPD.

What is CPD?

The concept of continuing to learn during a career as a doctor is as old as the profession itself. CPD was first differentiated from the older and narrower term Continuing Medical Education (CME) in the UK in 1993 to include learning beyond keeping abreast of relevant developments. [1, 2] In the US, however, the terms are often used interchangeably. [3]

The UK General Medical Council (GMC) defines CPD as “any learning outside of undergraduate education or postgraduate training that helps you maintain and improve your performance. It covers the development of your knowledge, skills, attitudes and behaviours across all areas of your professional practice. It includes both formal and informal learning activities.”[4] Although many organisations use a definition based on the model proposed by the UK Academy of Royal Medical Colleges. [5]

The American Academy of Pediatrics takes a broader view with the stated remit of CME/CPD being beyond medical practice, “The mission is to attain optimal physical, mental, and social health and well being for all infants, children, adolescents, and young adults.....To support this mission, the AAP makes continuing medical education (CME) and continuous professional development (CPD) priorities of the organization” [3]

There is a huge spectrum of activities that can constitute CPD from intuitive learning during routine practice to mandatory training required by employing organisations. Indeed the UK Royal College of Paediatrics and Child Health (RCPCH) increasingly recognises the necessity of “flexibility, balance and self-accreditation.” [6]. Key is that CPD is more than just clinical learning. Doctors need to develop many other skills including teaching, leadership and appraisal.

Is there a problem with CPD?

Concerns do exist about the nature of CPD activities and their true impact on clinical work;

“Whilst there is an absolute belief in most cases that Doctors’ participation in CPD does improve practice and performance, respondents were hard pushed to give examples of this.” [7]

Additionally, there are concerns about some approaches such as requirements to reflect and whether this constitutes valid reflection. [8] Also, although clinical medicine has always evolved, the rate of change is increasing, “The importance of physicians being self-directed, ongoing learners has increased, particularly in the context of incremental rates of growth of knowledge and information.” [9] This importance is evident in the increasing role of reflection in the most recent RCPCH guidance. [6]

This focus on self-direction is, however, coming at a time of increasing regulation and oversight although this is not unique to medicine and is not a new phenomenon with Lowenthal usefully summarising changes in the US since the late 1960s. [10]

Potentially, we have a ‘perfect storm’ of overall increasing demands on doctors’ time, increasingly complex caseloads and the need to work across different agencies and therefore a greater development need alongside rapidly evolving clinical developments. This is compounded by a need to show value for money and outcomes.

To make sense of where we are we need to consider the nature of the learners involved and place this in the context of the prevailing culture of medical work and learning.

Doctors as learners

Doctors are usually presumed to be especially intuitive adult learners and to have positively entered a career with an inherent interest and enthusiasm to learn and develop with many published descriptions of the lifelong nature of medical learning.[11] The need for physicians to engage in effective self-regulated learning is said to be well documented and linked to the quality of healthcare [13] although the sources quoted are often tenuous, reflecting a lack of clarity in the research base.

Adult Learning

There are a number of theories applied to adult learning, usefully summarised by Kaufman and Mann. [12] Although it is argued whether there truly is a distinct entity of ‘androgogy’ – the teaching of adults as opposed to pedagogy - the teaching of children [12], there is clear agreement that there are core principles and Knowles’ Andrological Assumptions are a helpful model to consider as are the resulting andrological principles [box 1]. Those interested can review full theoretical explorations [13], but good summaries exist. [14]

Box 1

1. Self-direction (the ability to determine and find ways of meeting their own learning needs)
2. Integration of prior experience
3. Readiness to learn relating to their work role
4. Immediacy of application
5. Greater overall internal motivation.

Simplified from Pappas, C. [14]

From this it is easy to see that CPD events that do not acknowledge and allow for prior experience and immediate applicability to a learner’s context will potentially fail and also that denial of self-direction is problematic;

When an adult learner “finds himself [sic] in a situation in which he is not allowed to be self-directing, he experiences a tension between that situation and his self-concept. His reaction is bound to be tainted with resentment and resistance” [13]

Adult professionals certainly learn within a context of practice with Schon noting the importance of reflection on something real that has happened (reflecting on action). [15] This puts reflection at the centre of thinking about professional learning, something that may not always be possible for busy doctors who may get caught up in just working.

The prevailing culture

Compulsion

Professional groups were historically presumed to just get on with self-development but increasingly they have been less trusted to do so without oversight [1] by both standard setting organisations [16] and regulatory bodies [17] in part because maintaining self-motivation can be challenging in a long busy career, “Although intrinsic motivation results in high-quality learning, educators cannot depend on all learners to be intrinsically motivated across all learning tasks” [18]

Compulsion is also used when those perceived to be most in need do not recognise it and do not engage. [7]

CPD is also often mandated either for all members of a specified group or specified for individuals as part of formal processes, such as Personal Development Plans (PDPs) agreed with appraisers and in the UK is now wrapped up with revalidation. Concordance is then policed, sometimes by completion of on-line assessments, and counting hours of attendance (CPD points) and by compulsory written reflections on events.

Yet, there is a lack of evidence that compulsion deals with isolated poor practice;

“The GMC should commission research on how CPD (or the lack of it) is linked to poor performance and concerns with fitness to practise.” [13]

And that compulsion limits flexibility;

“it is important that Trusts and the GMC continue to recognise and support informal learning as an important component of CPD” [7]

Accountability

Organisations are also under financial and regulatory pressure to show ‘value’ – demonstrable outcomes for investment in staff time, facilities and funding. This often results in a focus on recording of activity. In the UK this is in part related to National Health Service (NHS) organisations demonstrating development of a ‘Competent & Capable Workforce’ as part of meeting risk management standards.[19] This tends to result in ‘top down’ provision with an emphasis on didactic sessions and e-learning packages with little self-direction.

The ‘tick box’ culture.

The combined focus on compulsion and accountability has led to what many have described as a ‘tick box’ culture;

“[CPD] has been mainly a tick box to ensure you get enough points rather than looking at what CPD you actually did. (Large Acute Hospital, Medical Director)” [7]

There is also clear doubt about the evidence that the CPD 'point collecting' approach has much to recommend it, particularly if hours of activity and simple presence is counted irrespective of engagement.

There are, however, signs of change with the new UK RCPCH guidance making it easier for busy clinicians to demonstrate gains from their CPD recognising that the focus of CPD needs to be on what has been learnt and its effect on practice, rather than on the acquisition of CPD points. [6]

Reflection

Reflection is seen as central to self-regulated learning but we now have appraisal portfolio systems and course CPD forms with mandatory reflection, "The appearance of complying with requirements to 'reflect' becomes more important than the intended educational purpose" [8], raising the questions as to whether 'forcing to reflect' is beneficial by encouraging the reluctant (who will then engage) or detrimental by forcing 'reflection by rote'.

Appraisal

The GMC has no doubt that, "CPD is more effective where it is integrated with appraisal, linked to PDPs and aligned with organisational objectives" [7] although this is at odds with unplanned and serendipitous learning (see worked example 3)

In summary

CPD has moved from the realm of a self-regulated learning activity [18] to one that is increasingly mandated and codified and now, explicitly linked to revalidation [16] although the degree to which this adds quality to the outcome is disputed. [7]

Our learners (and their patients) will benefit from self-directed adult learners addressing their learning needs in a way that encourages deep learning and application of gains that improves care. Unfortunately a combination of the current culture alongside the recognition that a degree of compulsion may be needed (both for the individual and to ensure that organisations give individuals time to learn) can act against this.

Whilst accepting the need to demonstrate effectiveness, value for money etc., the very actions (for example forced reflection and certain ways of recording activity) might act against accepted theories of learning and make the desired outcomes (often around improved care) less likely. Indeed, if success is all about goal setting and a sense of self-efficacy [18], how can anything be achieved if mandated external goals are not valued?

Getting back to basics....

Learning planning;

Returning to individuals, how do they ensure that they are using personal development opportunities as best they can? This is especially challenging as newer ways of working including increasing numbers of doctors and shift systems mean that traditional events such as "grand rounds" are not always so easy to organise or attend.

At its most basic, CPD comprises of a series of learning events, whether ad hoc, self proposed or mandated. Whether explicit or not such events should follow the basic rules of learning planning. There is an intention, an action and an outcome.

There are intended learning outcomes, the knowledge, skills and attitudes to be gained by the learner, teaching and learning activities aimed at producing these outcomes; and, to a varying degree, assessments and tasks, the processes by which the outcomes of learning are measured and recorded.[20] For learning to be effective, outcomes need to be relevant to the needs of the learner (whether self-perceived or not), the activities undertaken need to specifically address these outcomes and some effort is needed to show whether they have been achieved by the learning. Importantly, outcomes need to go beyond gaining new knowledge with issues of skills and attitude [21] often as important in achieving desired change. If the gap is knowledge, the relevant activity may comprise simply finding up to date facts and storing them somewhere accessible. If the gap involves skills or attitudes, then the activity has got to be something that specifically changes or develops those. When teaching directly and fully address intended outcomes and are successfully measured by relevant assessments, this is described educationally as 'alignment'.[20]

Worked examples

1. I have a learning need for my clinical practice but I don't know how to start addressing it

The first step is defining the need and then transferring this into the language of learning outcomes. What is the challenge? What is the gap in current practice? How specifically can this be bridged? This may require updated or improved knowledge (about newer investigations or management, for example), specific skills (diagnostic, communication, practical) or more philosophical issues including new ways to think about certain issues (attitudes). Also, how will it be clear that the challenge has been met?

Once clarified, it should be easier to identify the route to improving things (Teaching and learning activities) such as background reading, attendance at a specific course/ event, a team activity etc. Also, if funding and resources are an issue, there should now be a clear case to make with proposed actions and ways of measuring outcome which should improve the chances of managerial support.

2. Mandatory training can risk achieving little – can we improve it?

Mandatory training frustrates many, especially if it is seen as irrelevant or repetitious. Indeed by often being a standard package with no allowance for prior experience and current service requirements, this goes directly against good practice for adult learners. In terms of provision, the key for those designing mandatory training is to focus on the needs of adult learners, taking into account the learner's past experience; whilst it may be more time-consuming to design such mandatory training sessions, the possibility of a pre-test and tailored training to match the learner's specific needs is likely to be better received by the learners.

At one level, a learner can simply attempt to 'grin and bear it' but they should make all reasonable attempts to understand the need for particular training and concord with safety critical issues as well as providing constructive feedback about how the learning might be better delivered.

3. I want to go to a national conference. How do I convince my employer to allow and fund this?

National conferences were once a common part of clinical CPD yet many now struggle to attend due to time and funding issues. On the positive side, they allow 'time out', can result in substantive networking opportunities and are a real opportunity for serendipitous learning – a particularly good way to learn the “unknown unknowns – there are things we do not know we don't know”[22] as there are opportunities to attend sessions 'on a whim'. However, conferences are often seen as expensive, may be broad in topic (making it harder to justify attendance on the basis of a specific learning need) and require time away from service.

The key is to make a case based on learning need (a good starting point is whether you can really justify attendance on learning grounds for yourself) but to also explicitly plan how to demonstrate learning and maximise learning for others. This could be via tweeting key learning points for colleagues, producing a summary with web links or appropriate 'new and best practice' slots at team learning events or teaching elements at handover. Serendipitous learning should be highlighted and reflected on and discussed at appraisal to show the value retrospectively and increase the chance of future attendances for yourself and colleagues.

4. I am struggling to meet the CPD requirements for my appraisal because of increasing clinical demands.

There are many challenging discussions going on about workload at the moment and access to CPD can sometimes end up at the back of the queue. However, ongoing service development needs clinician development and revalidation requires evidence of CPD. Clearly, this becomes part of a wider job plan discussion. If there is too much work for the staff available, convincing a clinical director that something is vital may just get it added to a to-do lists. The key here is to ensure explicit alignment of learning need with service, particularly efficiency of service, ensure maximal use is made of appraisal (perhaps identifying major needs a year or two in advance) alongside being seen to concord with mandatory CPD requirements.

Finally, remember that writing a PDP usually comes at the end of an appraisal meeting. Ensure you have one drafted in advance and that this aligns with the rest of your appraisal – that the developments you want to undertake and the issues you wish to resolve naturally lead to the appropriate development that you plan.

Summary

Few doubt that career-long learning is key to quality practice yet this can be challenging to quantify. There are clear models of effective learning for adults and professionals and it is ironic that many of the current pressures act against these. Basic learning planning is vital as it ensures that 'regulations' are applied in ways that are mindful of the nature of the learners and the chance of the intervention having an effect. Putting learning and the learner at the centre, whilst ensuring evaluations of interventions offers the best chance of compromise between the current climate of compliance and the need for flexible, effective learning. The revised RCPCH CPD scheme is a useful resource for busy UK paediatricians to

clarify CPD requirements, as well as providing a simplified mechanism for demonstrating CPD. [6]

Links

Details of the current RCPCH CPD scheme

<http://www.rcpch.ac.uk/training-examinations-professional-development/continuing-professional-development-cpd/continuing-pr>

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